The Delta Variant | Fleming-Method

10-12 minutes

The Delta Variant

Quite Possibly The Ultimate Reason Why the Mass Vaccination Program must Stop and Why We Must Focus our Efforts on Treating the Infection & The Resulting InflammoThrombotic Response (ITR) Known as COVID.

In 2019 the release of SARS-CoV-2 was followed with a warning by a few of us, that this Gain-of-Function virus had significant regions within it's genetic code that should concern all of us.

More than a year later and more than 4-million deaths world wide we are looking at the evolution of this man-made virus; evolution we expected to see and here it is.

Viruses like all life, including this man-made virus, evolve to survive.

Viruses depend upon a host to live and reproduce itself. In the case of SARS-CoV-2 that means people. If the virus becomes too dangerous and kills you, then the virus will NOT survive and will not be able to spread to other people. It will die inside you. [Yes, a few might escape before you die, but this is not going to continue very long before the virus can no longer escape.]

Viruses evolve to survive. When pressure is placed on a living organism, those that are too weak or susceptible to the pressure will die; leaving only those without that weakness alive to survive and perpetuate the next generation. In the next section you will see how this relates to bacteria and antibiotics. Later we will see how this relates to SARS-CoV-2 and vaccines.

When you become infected with a bacteria, or a virus, or something else, your immune system will try to fight off the infection. As I have talked about elsewhere on this website, and in multiple videos on this website, the first part of your immune system, called the innate acute T-cell response will recognize the infection in approximately 3-5 days. Following this, your body's immune system will release a series of chemicals designed to kill your infected cells and to form blood clots to both starve the infected area and try to reduce the spread of the infection to other parts of your body. Other chemicals are released to try to prevent the infection from reproducing itself. This is the beginning of the InflammoThrombotic Response (ITR) I have talked about since 1994.

If the infection is not brought under control during the first 3-5 days and the infection continues to grow and multiply, a back up system helps you bring the infection under control. This part of your immune system is called the

delayed adaptive humoral antibody system. This part of your immune system requires B-cells, the antibody producing cells, and occurs roughly 7-10 days after you become infected. The goal of this part of your immune system is similar to the the T-cell response. Chemicals are released to cause harm to the invading virus (or bacteria, or fungus, et cetera) and the cells of your body that are infected. These chemicals cause blood clotting to wall of the invader and starve it to death, as well as kill infected cells. The one additional thing that this delayed adaptive humoral antibody system does is to produce antibodies.

Antibodies are built by your immune system, that recognize and attack something foreign to your body; viz. the specific cause of infection. This foreign material is called an antigen. Antigens that are part of the SARS-CoV-2 virus (the spike protein) is what the PCR test tries to find. When used properly PCR will look for the genetic code that makes the proteins found in the spike protein of SARS-CoV-2.

Once made, these antibodies then attach themselves to the invading antigen (e.g. virus) in an effort to prevent the SARS-CoV-2 virus from infecting and harming your body. If you become infected with SARS-CoV-2 because someone else transmitted it to you (person-to-person), you will not only have an innate T-cell response that will release chemicals to attack the virus; you will also make antibodies to all of the virus; not just part of it.

However, if the only thing your body sees is the spike protein produced inside your cells because you took a drug vaccine biologic that infects your cells with the genetic code to make a specific single type of spike protein, then the only immune response you can make is to that specific type of spike protein - nothing else; unlike natural immunity obtained by person-to-person transfer.

There will be no T-cell or B-cell (antibody) immunity to the other parts of the SARS-CoV-2 virus, or to other variants of the spike protein, because your body will not have seen those parts of the virus or other variants of the spike protein. You will have no immunity to spike proteins that look structurally different from that produced by your cells according to the genetic code injected into your body by the drug vaccines.

This means that if and when you become exposed to a different variant of SARS-CoV-2, and there will never be only one type of SARS-CoV-2 virus floating around, any more than there will be only one type of person floating around, then you will have little or no immunity based upon the drug vaccine itself.

If you have acquired (obtained) natural immunity due to being infected by the virus, then you will have an immune response (immunity) to all the various parts of the SARS-CoV-2 virus and you will not be dependent upon a specific antibody to one version of the spike protein to protect your body. You will also most likely have been exposed to more than one variant of SARS-CoV-2 and will develop antibodies (and T-cell response) to the different variants.

If however your immunity is dependent upon being vaccinated to a specific version (variant) of the spike protein, then the T-cell and B-cell (antibody) response will recognize that version (variant) of SARS-CoV-2. That version (variant) of the virus will undoubtedly be successfully attacked, while the other versions (e.g. the Delta variant), most likely will not. These other variants will survive to infect you and others as you share the infection.

This process of one variant surviving while another is killed off, is called Natural Selection; however, it is a very specific type of Natural Selection as it is the result of human intervention. This type of natural selection is called SELECTION PRESSURE. Namely, the variants which do not have the same spike protein you made antibodies to from the drug vaccine, will be the ones that survive.

Since vaccines do not prevent infection (they shorten the amount of time it takes your body to respond to the infection), and vaccines do not prevent you from transmitting/spreading the infection; then the drug vaccines are putting SELECTIVE PRESSURE on SARS-CoV-2, resulting in a survival advantage for Delta and other variants whose spike proteins are sufficiently different from the spike proteins made after the drug vaccines infect our cells.

This means that the vaccination programs are selectively promoting the survival and spread of the variants INCLUDING THE DELTA VARIANT.
This can be seen by looking at the change in SARS-CoV-2 variants following vaccination campaigns (as shown below).

Vaccines Do NOT Prevent Infection.
However, vaccines can reduce your symptoms thereby making you an asymptomatic or less symptomatic carrier - including a Delta Variant Carrier.

An Example of Medically Induced Selective Pressure Upon Bacteria Following the Indiscriminate Using Antibiotics.

To better understand how human intervention can encourage one form (variant) of an infectious agent to survive while killing off others; let's look at an all too common medical problem faced every day by physicians. Antibiotic resistant strains of bacteria, which in some instances can be life threatening.

An Example of Medically (Government) Induced Selective Pressure Upon SARS-CoV-2 Following the Indiscriminate Use of Experimental Vaccines.

Prior vaccination programs have developed vaccines using attenuated (weakened) versions of a particular virus. Not a single variant or version of the virus, but most if not all of the versions of the virus that you might come into contact with. These vaccines successfully eradicated many of these diseases, allowing people to develop memory cells (both T and B-cells) for long term immunity and protection. In some instances they totally eradicated the diseases protecting future generations.

As a result of these well researched and thought out vaccine programs, programs that took many years to do correctly, immunity in vaccinated

individuals developed to all parts of the virus (or bacteria) and not just a single variant of the virus.

Consequently we did not see variants of these viruses popping up around the world, and we did not have to reach some magic (as it keeps changing) level of vaccination.

The Forced Mandated Vaccination Programs Were Followed by Selective Pressure Evolution of the DELTA & other Variants.

If we look at the pattern of SARS-CoV-2 variants and the mass drug vaccination programs occurring, we can see that the variants have followed the vaccination programs.

This suggests either

(1) the variants are part of the drug vaccines themselves, or
(2) that the drug vaccine programs have resulted in the Selective Pressure to give a survival advantage to variants like DELTA.

Either way the data shows a clear relationship between the vaccination programs and the SELECTION of the Variants like DELTA.

The Greater the Mutational Change in the Spike Protein from the Original SARS-CoV-2,

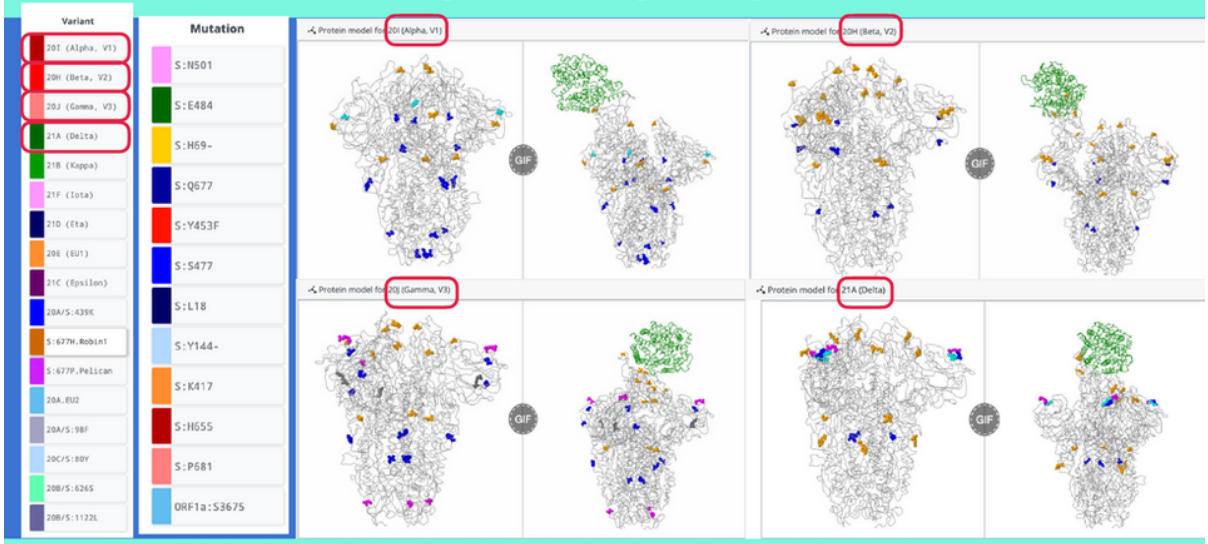
The Greater the Difference in the Structure of the Spike Protein in the Variants,

The Less Effective the Vaccines Have Become,

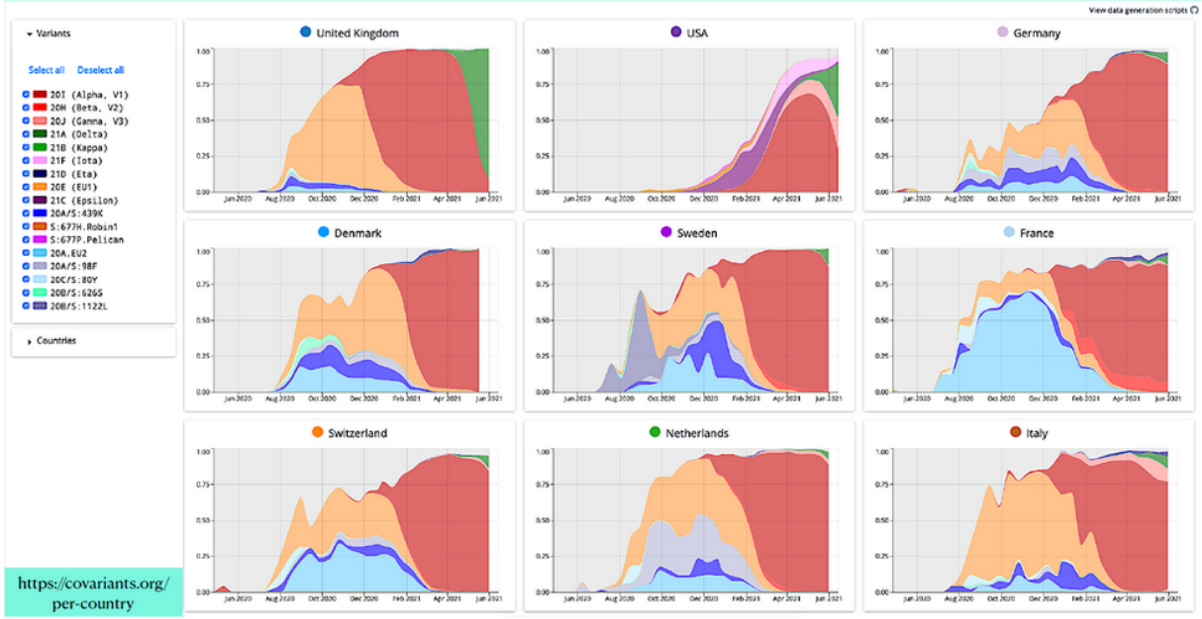
The Greater The Spread of the Variants Around the World.

By July of 2021
The Global Pattern for SARS-CoV-2 Variants Was
Alpha (V1), Beta (V2), and Gamma (V3).

The Most Infectious SARS-CoV-2 Viruses are Those Undergoing the Greatest Mutational Change - Including Changes in the Gain-of-Function



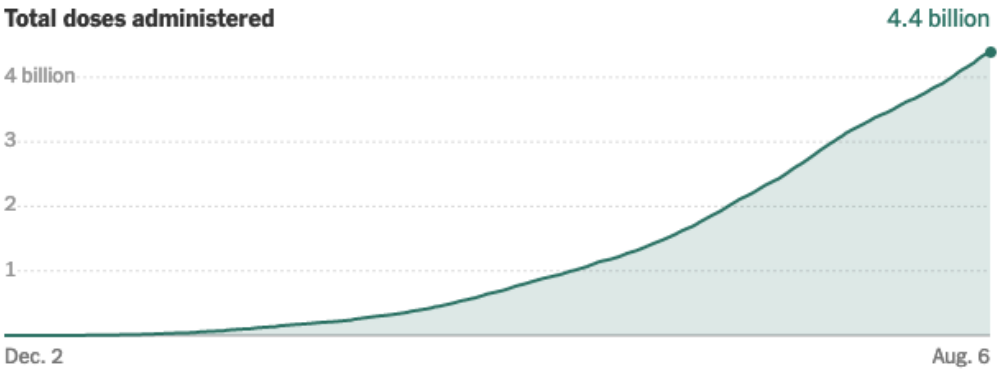
With special thanks to the work of Professors Emma Hodcroft, Jean-Claude Perez, and Luc Montagnier. https://covariants.org/variants/S.Q677H.Robin1



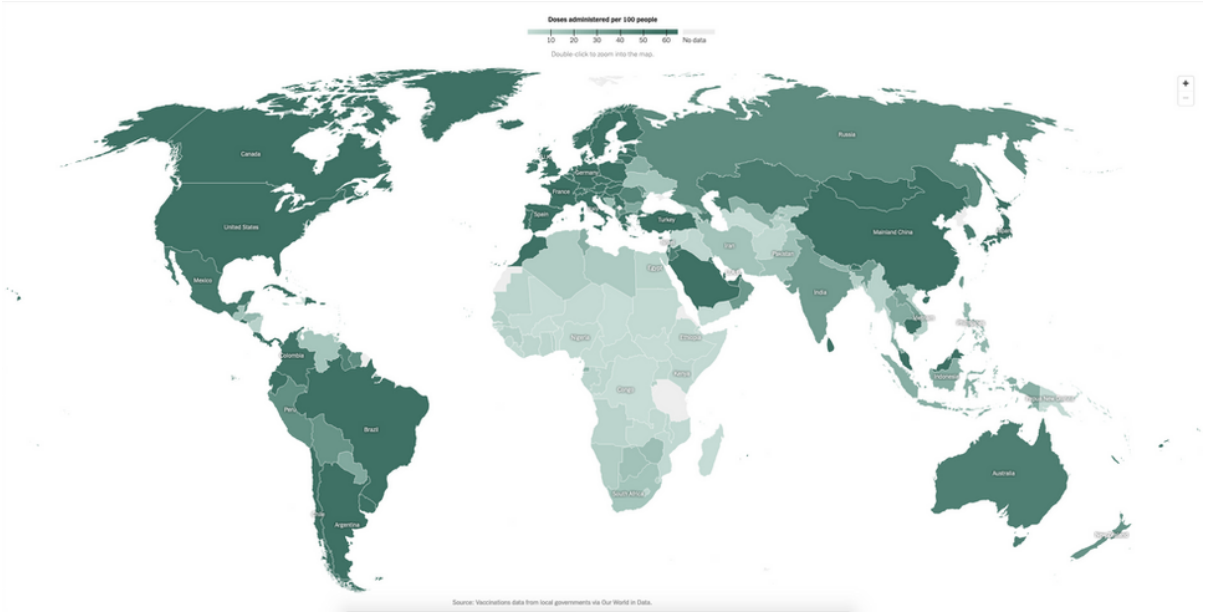
https://covariants.org/per-country

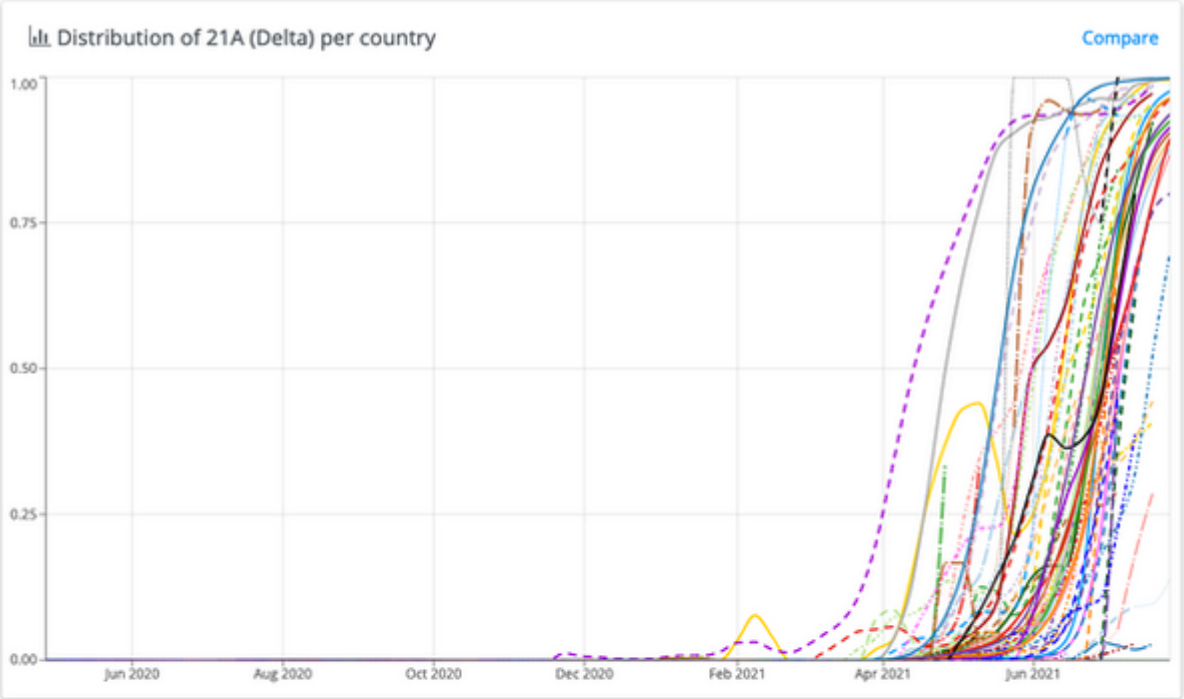
Tracking Coronavirus Vaccinations Around the World

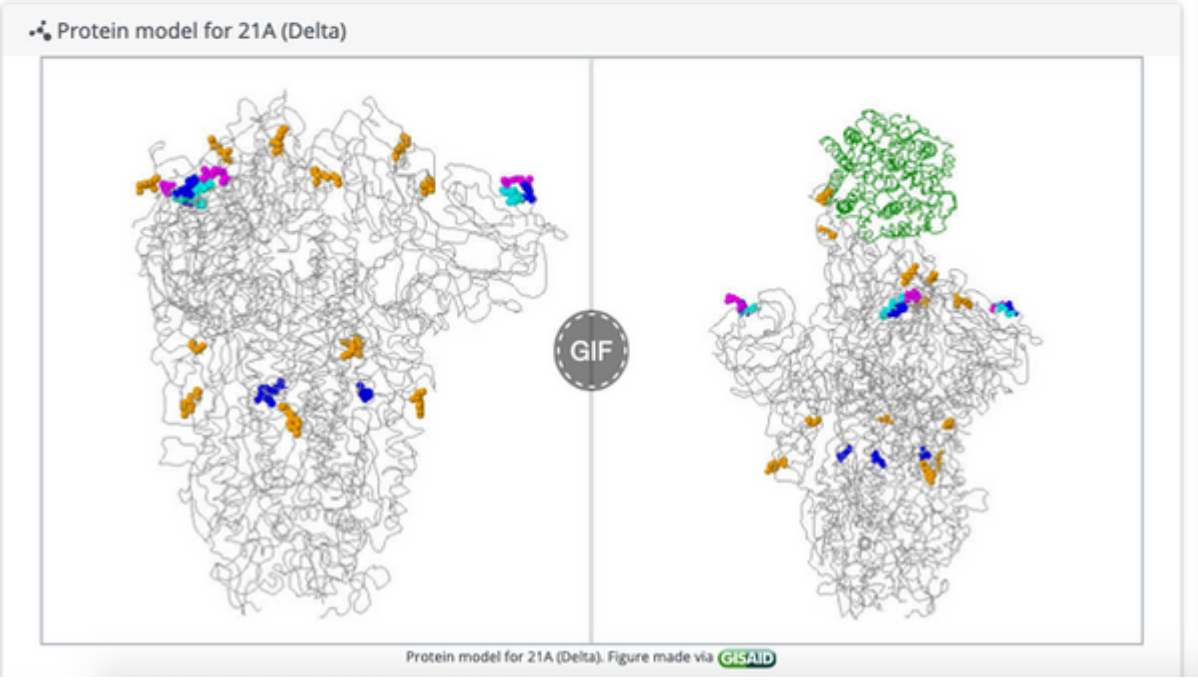
By Josh Holder Updated Aug. 7, 2021



More than 4.4 billion vaccine doses have been administered worldwide, equal to 57 doses for every 100 people. There is already a stark gap between vaccination programs in different countries, as this map shows.



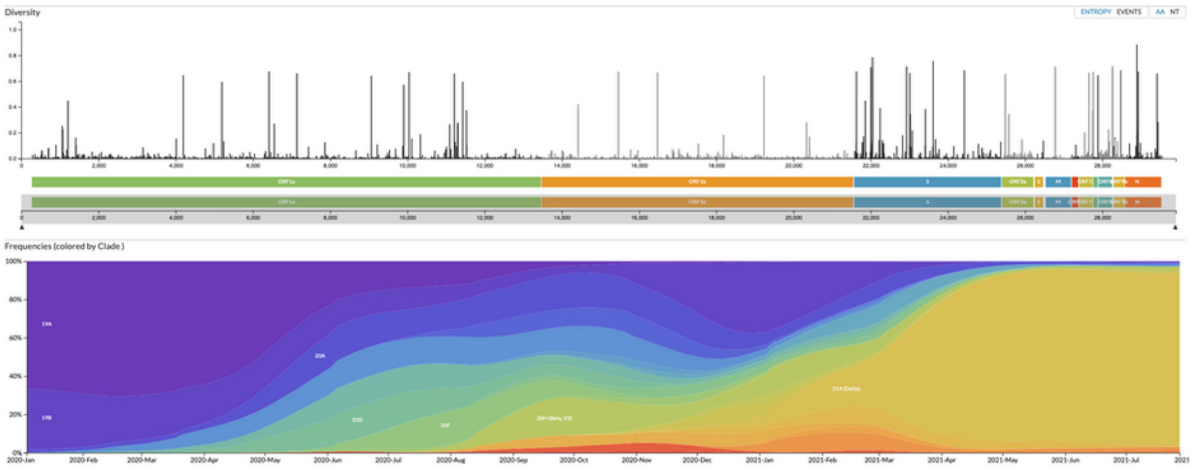

Distribution of 21A (Delta) per country
Compare
1.00
0.75
0.50
0.25
0.00
Jun 2020
Aug 2020
Oct 2020
Dec 2020
Feb 2021
Apr 2021
Jun 2021

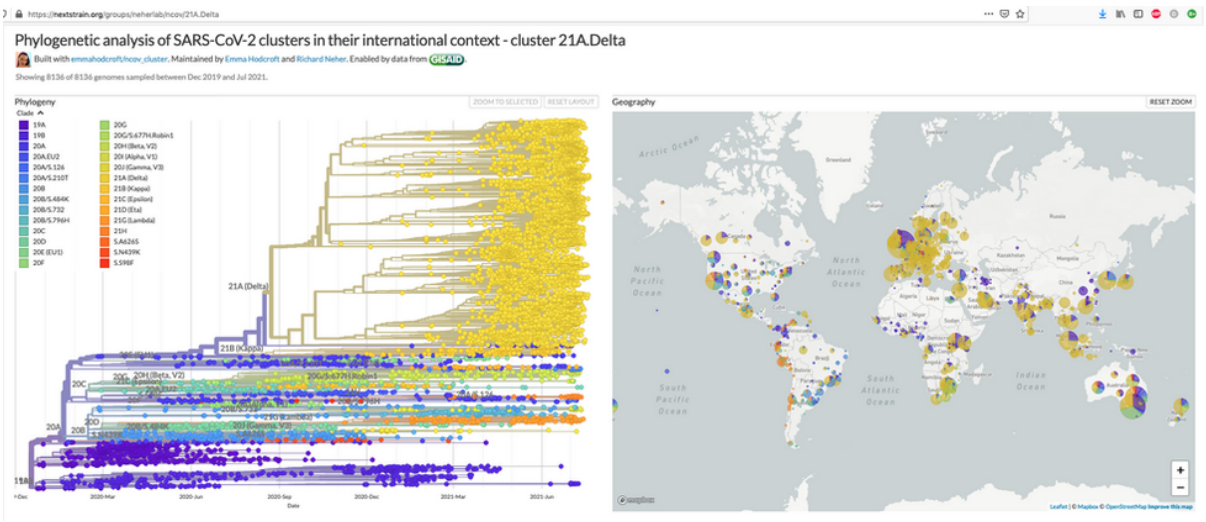

Protein model for 21A (Delta)
GIF
Protein model for 21A (Delta). Figure made via GISAID

26 Jul 2021 - 02 Aug 2021

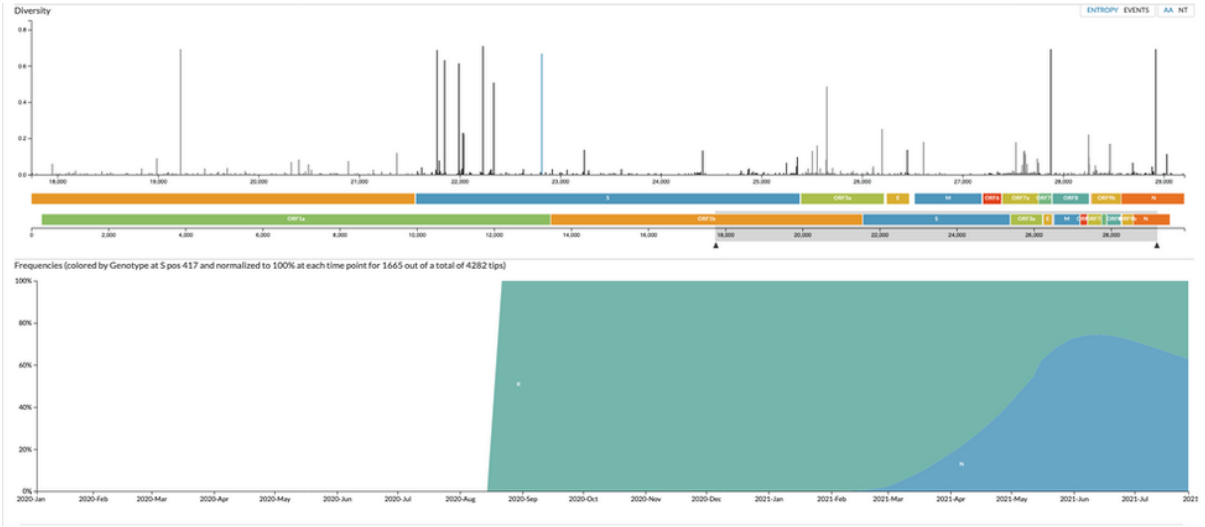
Country	Frequency
United Kingdom	1.00
Singapore	1.00
Australia	1.00
Denmark	0.98
Switzerland	0.96
South Africa	0.96
Indonesia	0.96
USA	0.94
Germany	0.94
Netherlands	0.92
Sweden	0.91
Italy	0.90
Belgium	0.89
Spain	0.89
France	0.88
Norway	0.87
Poland	0.80
Japan	0.70
Brazil	0.14
Argentina	-

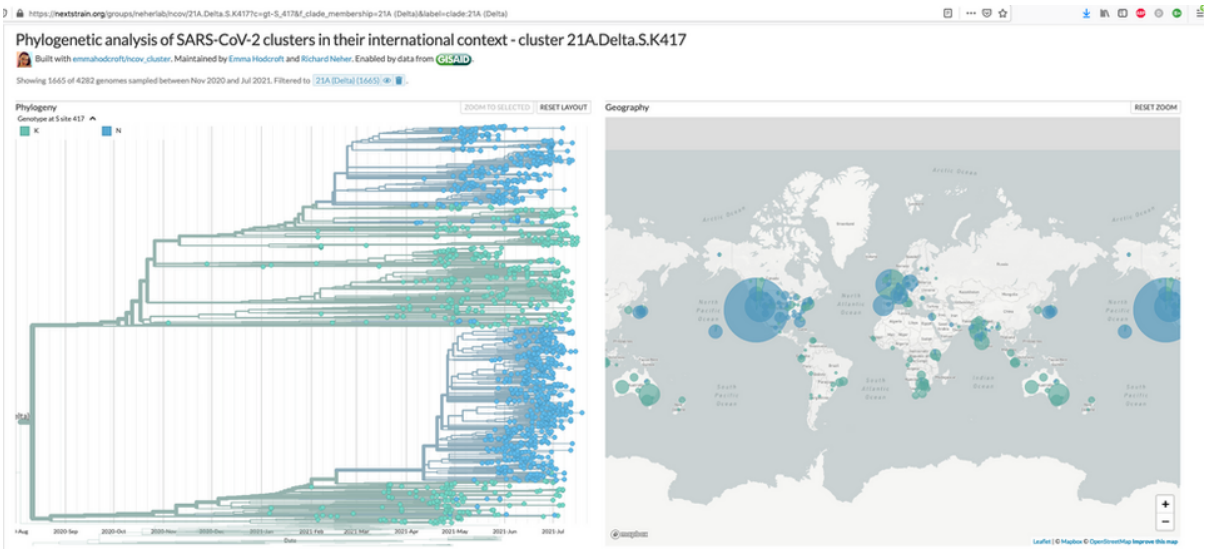
★ Interpolated values





With Still Further Selective Pressure Seeing Variant Shifts to 21A Delta S K417





Hospitalized or fatal COVID-19 vaccine breakthrough cases reported to CDC as of August 2, 2021

As of August 2, 2021, more than 164 million people in the United States had been fully vaccinated against COVID-19.

During the same time, CDC received reports from 49 U.S. states and territories of 7,525 patients with COVID-19 vaccine breakthrough infection who were hospitalized or died.

Hospitalized or fatal vaccine breakthrough cases reported to CDC	**7,525**	
Female	3,615	(48%)
People aged ≥65 years	5,557	(74%)
Asymptomatic infections	1,347	(18%)
Hospitalizations*	7,101	(94%)
Deaths†	1,507	(20%)

*1,816 (26%) of 7,101 hospitalizations reported as asymptomatic or not related to COVID-19.
†316 (21%) of 1,507 fatal cases reported as asymptomatic or not related to COVID-19.

Previous data on all vaccine breakthrough cases reported to CDC from January–April 2021 are available.

When added to the 10,262 SARS-CoV-2 Breakthrough Cases from January to April of 2021, the CDC has recognized 17,787 Cases of Individuals Diagnosed with SARS-CoV-2 Infections After Being Vaccinated.

https://www.cdc.gov/mmwr/volumes/70/wr/mm7021e3.htm

A total of 10,262 SARS-CoV-2 vaccine breakthrough infections had been reported from 46 U.S. states and territories as of April 30, 2021. Among these cases, 6,446 (63%) occurred in females, and the median patient age was 58 years (interquartile range = 40–74 years). Based on preliminary data, 2,725 (27%) vaccine breakthrough infections were asymptomatic, 995 (10%) patients were known to be hospitalized, and 160 (2%) patients died. Among the 995 hospitalized patients, 289 (29%) were asymptomatic or hospitalized for a reason unrelated to COVID-19. The median age of patients who died was 82 years (interquartile range = 71–89 years); 28 (18%) decedents were asymptomatic or died from a cause unrelated to COVID-19. Sequence data were available from 555 (5%) reported cases, 356 (64%) of which were identified as SARS-CoV-2 variants of concern,[§] including B.1.1.7 (199; 56%), B.1.429 (88; 25%), B.1.427 (28; 8%), P.1 (28; 8%), and B.1.351 (13; 4%).

Recapping on Selective Pressure and Variants of SARS-CoV-2.
An Opportunity to do this Right.